State of Idaho Emergency Medical Services Bureau

Provider Application Form

Level Applied For: ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT-A ☐ EMT-Paramedic

Type: ☐ Initial ☐ Recertification ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

Applicant Information:

Social Security # ___ - __ - ____ Date of Birth __ / __ / ____ Drivers License # _____ DL State ____

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State ____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ E-Mail _____

Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

Signature Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification: *Volunteer* *Career*

☐ True ☐ Full Time

☐ Compensated ☐ Part Time

Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed

For Bureau Use Only

Original Date Received in RO	CHC Scan Date (PROV) _____ CHC Complete Date (FULL) _____ Course # _____ NR Written Date _____ NR Practical Date _____ Ambulance Rating (if AEMTA) Date _____ Included ☐	Original Date Received in C&L	**FR/BASIC** **Test Date: / Expiration:** 06/01-11/01 12/31/2004 12/01-05/02 06/30/2005 06/02-11/02 12/31/2005 12/02-05/03 06/30/2006 06/03-11/03 12/31/2006 12/03-05/04 06/30/2007 06/04-11/04 12/31/2007 12/04-05/05 06/30/2008 06/05-11/05 12/31/2008 12/05-05/06 06/30/2009
Received in RO Complete	Cert. Fee Rcvd Date_____ Approval Date/Initial _____ Entered into Database _____ _____ Date Sent to CO _____ Previous ID State Certification ☐	Received in C&L Complete	**ADV/PAR** **Test Date: / Expiration:** 12/01-11/02 06/30/2004 12/02-11/03 06/30/2005 12/03-11/04 06/30/2006 12/04-11/05 06/30/2007 12/05-11/06 06/30/2008

EMT-AMBULANCE RATING REQUEST

Applicant Name:_____

I hereby verify the applicant named on this form has completed twenty-five (25) patient contacts under the supervision of personnel certified at the EMT-Basic level with an Ambulance rating or higher certification, between the dates of _____ and _____

Patient contacts are defined as those encounters consisting of a complete patient assessment or being the primary medical care provider for the duration of on-scene intervention or transport.

_____ _____

Signature of Chief Administrative Officer **Agency Name**

_____

Print name of Chief Administrative Officer

Revised 08/05/03